

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

### I. DISPUTE

1. a. Whether there should be additional reimbursement of \$170.00 for date of service, 08/07/01.
- b. The request was received on 07/24/02.

### II. EXHIBITS

1. Requestor, Exhibit I:

- a. TWCC 60 and Letter Requesting Dispute Resolution
- b. HCFA(s)
- c. EOB/TWCC 62 forms/Medical Audit summary
- d. Letter of Medical Necessity
- e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

Based on Commission Rule 133.307 (g) (4), the Division notified the insurance carrier Austin Representative of their copy of the request on 08/29/02. The Respondent did not submit a response to the request. The "No Response Submitted" sheet is reflected in Exhibit II of the Commission's case file.

3. Notice of Additional Information Submitted by Requestor is reflected as Exhibit III of the Commission's case file.

### III. PARTIES' POSITIONS

1. Requestor: Letter dated 08/13/02

**"The IC purchased the Interferential Stimulator on 08-07-01. The Interferential Stimulator cannot be used without electrodes. We supplied 3 units/months of electrodes and this should have been reimbursed at \$85.00 per unit/month or \$85.00 X 3 units/months = \$255.00. The IC has reimbursed \$85.00 of the \$255.00 MAR. In box 24 G of the HCFA it states the units as '3', This [sic] is 9 pkgs. 4/pack of electrodes or a total of 36 electrodes. Electrodes should be replaced every 10 to 15 Days [sic] to prevent bacteria build up and the use of older electrodes does not provide adequate contact to achieve maximum benefit of the unit. We are instructed by... (TWCC Compliance and Practice representative) that our billing to**

**and from dates should be the date we rendered the service. (When you have a prescription filled at a pharmacy, the pharmacy bills the IC'S [sic] the date the service was rendered not the dates the prescription will be taken or the date the patient will finish using the medication.).... I respectfully submit to you 1) A position statement 2) a LMN 3) A copy of the 'D' codes and 4) three EOB's from other IC'S reimbursed correctly for the same services. The submitted documentation supports unfair and unreasonable reimbursement. I have tried to speak with this IC five different times on this DOS as well as submitting a certified request for reconsideration attaching a copy of the 'D' codes. We did not get a reconsideration EOB until after we filed this dispute (we filed the dispute on 07-24-02 and the IC's EOB is dated 07-26-02) and they still are denying the additional monies due. Again the IC's EOB states '1' under the units supplied. According to the Medical Fee Guideline effective April 1, 1996, Paragraph VI. [sic] of the General Instructions states that the insurance carrier will reimburse the lesser of the billed charge, or the MAR. DME Ground Rules state a fair and reasonable amount is the same as in the original DME (D-Codes) Fee Schedule."**

2. Respondent: No response submitted.

#### **IV. FINDINGS**

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 08/07/01.
2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.
3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier \$270.00 for services rendered on the date above.
4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor \$85.00 for services rendered on the date above and denied reimbursement as "F REDUCTION ACCORDING TO MEDICAL FEE GUIDELINE".
5. Per the Requestor's Table of Disputed Services, the amount in dispute is \$170.00 for services rendered on the date of service in dispute above.
6. The Carrier did not respond to the provider's request for dispute resolution.
7. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
08/07/01	A4556	\$270.00 (3 units/months)	\$85.00	F	\$85.00/month	TWCC Rule 133.304 (c); MFG; DME GR; CPT Descriptor	TWCC Rule 133.304 states "The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)." The Carrier's EOB does not address or support their denial for the additional 2 units billed and the Carrier did not respond to the letter requesting additional information. Therefore, the Carrier has not supported their denial in accordance with TWCC Rule 133.304 ( c ). Reimbursement of <b>\$170.00</b> (\$85.00 x 2) is recommended.
<b>Totals</b>		\$270.00	\$85.00				The Requestor is entitled to reimbursement in the amount of <b>\$170.00</b> .

### V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **\$170.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 17<sup>th</sup> day of December 2002.

Denise Terry  
 Medical Dispute Resolution Officer  
 Medical Review Division  
 DT/dt